State Personnel Administration

CIGNA DENTAL CARE INSURANCE

EFFECTIVE DATE: January 1, 2008

CN3217600
05999780-01B

This document printed in December, 2008 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

CONNECTICUT GENERAL LIFE INSURANCE COMPANY
a CIGNA company (called CG) certifies that it insures certain Employees for the benefits provided by the following policy(s): No. 0599978-01B

POLICYHOLDER: TRUSTEE OF THE CIGNA DENTAL CARE/OPTIONS TRUST

GROUP POLICY(S) — COVERAGE
DENTAL INSURANCE

EMPLOYER: State Personnel Administration

EMPLOYER ACCOUNT NO.: 3217600

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This certificate takes the place of any other issued to you on a prior date which described the insurance.

Deborah Young

Deborah Young, Corporate Secretary

Explanation of Terms

You will find terms starting with capital letters throughout this certificate. To help you understand your benefits, most of these terms are defined within the text, or in the "Definitions" section.

Unless the context dictates otherwise, use of the male pronoun in this document will be deemed to include the female.

Notice Regarding Provider Directories and Provider Networks

This plan utilizes a network of dental care providers. You can access the list of providers who participate in the network by:

- visiting **www.cigna.com** or **www.mycigna.com**; or
- calling the following toll-free telephone number: **1-800-642-5810**

Your Participating Provider network consists of a group of local dental practitioners, of varied specialties as well as general practice, who are employed by, or contracted with, CIGNA HealthCare or CIGNA Dental Health.

FDRL32 M

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits.

A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for (or change) coverage only during each annual Open Enrollment Period. However, with the consent of your Emlpoyer, exceptions are allowed when you meet the criteria shown in the following Sections B through F.

B. Change of Status

If you choose single coverage upon your eligibility date, you may change to family coverage upon acquisition of a newly eligible Dependent (e.g., marriage, birth, adoption). You must, however, file a written request for a change in your coverage through your department within thirty (30) days of such change in family status. The effective date of coverage for the Dependent(s) shall be the first of the month following the date the appropriate premium payment is made.

If you lose all eligible Dependents (e.g., death, divorce, child exceeding eligible age), you may change from family to single coverage. You must, however, file a written request for a change in your coverage through your department within thirty (30) days of such change in family status. If no change request is filed with the thirty days, a change will not be permitted until the next Open Enrollment Period.

If you or your Dependent(s) lose dental coverage because the employment status of your spouse changes (e.g., due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence [including leaves that qualify under the Family and Medical Leave Act (FMLA)], or change in worksite), you may enroll in single or family coverage or change from single to family coverage, if you file the request within thirty (30) days of the event.

If your spouse gains coverage through a change of employment, you may change from family to single coverage, or discontinue family or single coverage, if you file the request within thirty (30) days following the event.

C. Court Order

A change in coverage due to, and consistent with, a court order of the Employee or other person to cover a Dependent.

D. Medicare or Medicaid Eligibility/Entitlement

The Employee, spouse or Dependent child cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

You must, however, file a written request for a change in your coverage through your department within thirty (30) days of such change in family status. If no change request is filed within thirty days, a change will not be permitted until the next Open Enrollment Period.

E. Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent child: (a) incurs a change, such as adding or deleting a benefit option; (b) allows election changes due to Special Enrollment, Change in Status, Court Order, or Medicare or Medicaid Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of coverage or open enrollment periods.

FDRL5 M

Eligibility -- Effective Date

Eligibility for Employee Insurance

You will become eligible for insurance on the date you complete the waiting period, if you are in a Class of Eligible Employees as follows:

- you are a full-time Employee of the State of Georgia (or of a State agency) working at least 30 hours per week on a continuous basis, and your employment is expected to last at least nine (9) months; or
- you are a public school teacher who is employed in a professionally certificated capacity, working 17.5 hours or more per week; or
- you are the Employee of a local school system, holding a non-certificated position, eligible to participate in the Teachers Retirement System, and working either: (a) at least 20 hours a week; or (b) 60% of the time necessary to carry out the duties of the position, if that is more than 20 hours per week; or
- you are an Employee who is eligible to participate in the Public School Employee Retiree System, and who works at least: (a) 15 hours per week; or (b) 60% of the time necessary to carry out the duties of the position, if that is more than 15 hours per week; or
- you are an Employee of a county or regional library working 17.5 hours or more per week; and
- you are otherwise deemed eligible by Federal or Georgia Law.

If you were previously insured and your insurance ceased, you must satisfy the Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period.

Initial Employee Group: You are in the Initial Employee Group if you are in the employ of an Employer on the Participation Date of the Employer.

New Employee Group: You are in the New Employee Group if your employment with an Employer starts after the Participation Date of that Employer.

Eligibility for Dependent Insurance

You will become eligible for Dependent Insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

A period of time ending on the first of the month following one full month of employment

Classes of Eligible Employees

Each Employee, as reported to by the Employer to CG

GM6000 EL 2V-46 ELI71M

Effective Date of Insurance

This plan is offered to you as an Employee. You will be required to pay the cost of the insurance for yourself and your eligible Dependents.

Coverage Effective Date - Employee

If you meet the conditions of insurability, your coverage under the policy shall become effective on the later of:

- The date of you become eligible, provided you are Actively at Work. If you are not Actively at Work on that day, the coverage will begin on:
  - the date that you return to work; or
  - the date you become eligible, if it is your scheduled day off and you were Actively at Work on the preceding scheduled work day; or
- First day of the Plan Year following the initial Open Enrollment Period, provided you are Actively at Work and you completed, signed, and submitted the Option Statement during such Open Enrollment Period; or
- First day of the Plan Year following any Open Enrollment Period subsequent to the initial Open Enrollment Period, provided you are Actively at Work and you completed, signed, and submitted an Option Statement during such Open Enrollment Period.
- For new hires, on the first day of the calendar month following one full month of employment.

Coverage Effective Date - Dependent

If you enroll for family coverage on your eligibility date, insurance for all your eligible Dependents shall be effective on the same date as your insurance. However, if any of your Dependents are confined in a Hospital or facility providing care or treatment for physical or mental infirmities on that date, insurance for such Dependent(s) shall become effective on the date following discharge or dismissal from the Hospital or facility.

If you do not enroll for family coverage on your eligibility date, you will be required to wait until the next Open Enrollment Period to become covered [unless you qualify under the section of this document entitled, "Effect of Section 125 Tax Regulations on This Plan"]. Insurance for your eligible Dependents shall be effective on the first day of the Plan Year that next follows the end of the Open Enrollment Period in which you elect it.

All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

Open Enrollment Period

The term Open Enrollment Period means a defined period of time in each calendar year, as designated by the State Personnel Administration, during which you have an opportunity to change your benefit elections.

Plan Year

The term Plan Year (also referred to as Contract Year) refers to the period of time beginning each January 1st and ending on the following December 31st.

Choice of Participating Dental Facility

When you elect Employee Insurance, you will select a Participating Dental Facility from the list provided by CDH. If your first choice of a Participating Dental Facility is not available, you will be notified by CDH of your designated Participating Dental Facility based on your alternate selection. You and each of your insured Dependents may select his or her own designated Participating Dental Facility. A transfer from one Participating Dental Facility to another Participating Dental Facility may be requested by you through CDH. Any such transfer will take effect on the first day of the month after it is authorized by CDH. A transfer will not be authorized if you or your Dependent has an outstanding balance at the Participating Dental Facility.

GM6000 EF17 ELI66V6 M

GM6000 EF 2 ELI70V3 M

CIGNA Dental Care Insurance

For You and Your Dependents

CG will pay for Covered Dental Services received by you or any one of your Dependents, excluding any dollar amounts listed in the Patient Charge Schedule (provided by CDH).

If you or any of your Dependents, while insured for these benefits, incur expenses for Emergency Dental Services received from a Participating or non-Participating General Dentist, CG will pay for the expenses in accordance with the Patient Charge Schedule. Benefits for Emergency Dental Services will not be denied on a prospective or retrospective basis.

"Emergency Services" are services provided for a condition of recent onset and sufficient severity--including, but not limited to, severe pain--that would lead a prudent person with an average knowledge of medicine and health to believe that his or her Sickness, Injury, or condition is such that a lack of immediate treatment may: (a) place the person's health in serious jeopardy; (b) cause serious impairment of bodily function; or (c) cause serious dysfunction of any bodily organ or part.

Benefits are payable under this plan for Covered Dental Services received:

- from your designated Participating Dental Facility; or
- by referral from your Participating General Dentist to a Specialist approved by CDH; or
- that are otherwise authorized by CDH; or
- as specified above for Emergency Dental Treatment.

Covered Dental Service

The term Covered Dental Service refers to a Dental Service listed in the Patient Charge Schedule when that Dental Service:

- is performed by, or under the direction of, the designated Participating Dental Facility; or upon referral by the Participating General Dentist to an approved Specialist and authorized by CDH; and
- is essential for the necessary care of the teeth and supporting structure (gums); and
- starts and is completed while the person is insured.

Services listed on the Patient Charge Schedule may be covered if performed by any licensed Dentist; however, the member payment fees listed on the Patient Charge Schedule will not apply to such services by non-contracted Dentists unless specifically arranged by CDH.

GM6000 DEN48 V44 M

A Dental Service is deemed to start when the actual performance of the service starts, except that:

- for fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth are fully prepared.
- for a crown, inlay, or onlay, it starts on the first date of preparation of the tooth involved.
- for root canal therapy, it starts when the pulp chamber of the tooth is opened.

Frequency

The frequency of certain Covered Dental Services, such as cleanings, is limited. Your Patient Charge Schedule lists any limitations of frequency.

Specialty Referrals

When specialized dental care services are required, a Participating General Dentist must initiate the referral process.

Covered specialists include:

- pediatric dentists – children's dentistry;
- endodontists – root canal treatment;
- periodontists – treatment of gums and bone;
- oral surgeons – complex extractions and other surgical procedures;
- orthodontists – tooth movement.

There is no coverage for prosthodontists or other specialists not listed above.

Upon payment approval by CDH, you and your Dependent will be liable for applicable fees, including fees for any dental service rendered but not listed in the Patient Charge Schedule. All fees correspond to the Patient Charge Schedule in effect on the date the procedure is initiated. If CDH does not approve payment, you must pay the Dentist's Usual Fees.

A person must be insured for these benefits when treatment by a Specialist is rendered. Such treatment must occur no later than 30 days from the approval by CDH. The x-rays taken by the Participating General Dentist must be sent to the Specialist to avoid excessive exposure to radiation and unnecessary expenses.

After completing specialty care, you should return to your Participating General Dentist for your general care. If you obtain additional specialized dental care services without a referral approved for payment after you have completed specialized care, you will be responsible for the Dentist's Usual Fees.

GM6000 DEN112V2 M

Pediatric Dentistry

If any Dependent child of yours under age 7 needs to be treated by a Pediatric Dentist, contact your Participating General Dentist for a specialty referral. Upon appropriate referral, your child may continue under the care of the Specialist, up to age 7, without additional referrals. If you need to change your child's Pediatric Dentist, you should return to your Participating General Dentist for a new referral, up to the child's 7th birthday.

Your Pediatric Specialist must submit each specialty treatment plan to CDH for payment authorization. CDH's standard payment authorization process will apply.

For children aged 7 or older, your Participating General Dentist will provide care. Exceptions for medical reasons may be considered on a case-by-case basis. For children aged 7 or older, if you continue to visit the Pediatric Dentist without a referral authorizing payment, you will be fully responsible for the Pediatric Dentist's Usual Fees.

Orthodontics

The following definitions apply:

- Orthodontic Treatment Plan and Records – The preparation of orthodontic records and a treatment plan by the Orthodontist.
- Interceptive Orthodontic Treatment – Treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
- Comprehensive Orthodontic Treatment – Treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention; and
- Retention (Post Treatment Stabilization) – The period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of your teeth.

The fees for your entire orthodontic case, including retention, will be based upon the Patient Charge Schedule in effect on the date of your visit for Treatment Plan and Records. This fee will apply, unless: (a) banding/appliance insertion does not occur within 90 days of such visit; (b) your treatment plan changes; or (c) there is an interruption in your coverage or treatment (in which case, a later change in the Patient Charge Schedule may apply).

The Charge for Orthodontic Treatment is based upon 24 months of interceptive and/or comprehensive treatment. If you require more than 24 months of treatment in total, the Specialist may charge you an additional amount for each additional month of treatment. If you require less than 24 months of treatment, your fees will be reduced on a prorated basis.

GM6000 DEN113V1 M

Additional Charges – The following orthodontic services are not covered:

- incremental costs associated with optional/elective materials, including, but not limited to, ceramic, clear lingual brackets, or other cosmetic appliances;
- orthognathic surgery and associated incremental costs;
- appliances to guide minor tooth movement;
- appliances to correct harmful habits; and
- services which are not typically included in orthodontic treatment. These services will be identified on a case-by-case basis.

Orthodontics in Progress

If orthodontic treatment is in progress for you or your Dependent at the time you enroll for insurance under this plan, call CDH at **1-800-642-5810** to find out if you are entitled to any benefits hereunder.

Oral Surgery

The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased, or if the removal is only for orthodontic reasons.

Complex Rehabilitation

A Complex Rehabilitation is an extensive dental restoration involving 6 or more "units" of crown and/or bridge in the same treatment plan. The crown and bridge charges listed in the Patient Charge Schedule are for each tooth (or "unit"). An additional amount is charged for each unit when a Complex Rehabilitation is performed.

GM6000 DEN114 M

Covered Dental Services will not include nor, where applicable, will payment be made for any:

- services performed solely for cosmetic reasons.
- replacement of fixed and/or removable prosthodontic or orthodontic appliances that have been lost; stolen; or damaged due to patient abuse, misuse, or neglect.
- procedures, appliances, or restorations, if the main purpose is to: (a) change vertical dimension (i.e., degree of separation of the jaw when teeth are in contact); (b) diagnose or treat conditions or dysfunction of the temporomandibular joint ("TMJ"); or (c) restore teeth which have been damaged by attrition, abrasion, erosion, and/or abfraction.
- prescription drugs.
- general anesthesia, sedation, and nitrous oxide, except as specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when Medically Necessary and provided in conjunction with Covered Dental Services performed by an oral surgeon or a periodontist.
- procedures or appliances for minor tooth guidance, or to control harmful habits.
- procedures or services associated with the placement or prosthodontic restoration of a dental implant.
- services, to the extent that they are compensable under any group medical plan.
- crowns or bridges used solely for splinting.
- resin-bonded retainers and associated pontics.
- hospitalization, including any associated incremental charges for dental services performed in a Hospital.

GM6000 DEN115 M

General Limitations

No payment will be made for expenses incurred or services received:

- for or in connection with an Injury or a Sickness which is covered under any workers' compensation or similar law;
- in a Hospital;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- which the person would not be legally required to pay;
- when charges would not have been made if the person had no insurance;
- for unnecessary care, treatment, or surgery;
- to the extent that you or any of your Dependents are in any way paid (or entitled to payment) for those expenses or services by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society;
- due to Injuries that are intentionally self-inflicted.

GM6000 GEN347 TN M

Coordination of Benefits

Note: Under this plan, Coordination of Benefits provisions apply ***only*** *to specialty care.*

This section applies if you or any of your Dependents are covered under more than one Plan, and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for dental care or treatment:

(1) Group insurance and/or group-type coverage, whether insured or self-insured, which can be neither purchased by the general public, nor individually underwritten, including closed panel coverage.

(2) Governmental benefits as permitted by law, excluding Medicaid, Medicare, and Medicare supplement policies.

(3) Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits for services rendered by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines its benefits after the benefits provided or paid by the Primary Plan (and that may reduce its benefits accordingly). A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided.

GM6000 COB11V7 M

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to, the following:

- An expense or service, or a portion of an expense or service, that is not covered by any of the Plans is not an Allowable Expense.
- If a person is covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If a person is covered by one Plan that provides services or supplies on the basis of reasonable and customary fees, and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If benefits for a person are reduced under the Primary Plan (through the imposition of a higher coinsurance percentage, a deductible, and/or a penalty) because he did not comply with Plan provisions, or because he did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and pre-authorization of services, as required.

Claim Determination Period

A plan year, but does not include any part of such a year during which a person is not covered under this policy (or any date before this section or any similar provision takes effect).

GM6000 COB12 M

Reasonable Cash Value

An amount which a duly-licensed provider of health care services usually charges patients, and which is within the range of fees usually

charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If a Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation will be utilized:

(1) The Plan that covers a person as an enrollee or an Employee shall be the Primary Plan, and the Plan that covers that person as a Dependent shall be the Secondary Plan;

(2) For a Dependent child whose parents are not divorced, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or Employee;

(3) For the Dependent child of divorced or separated parents, benefits shall be determined in the following order:

(a) first, if a court decree states that one parent is responsible for the child's health care expenses or health coverage, and the Plan for that parent has actual knowledge of the terms of the order (but only from the time of actual knowledge);

(b) then, the Plan of the parent with custody of the child;

(c) then, the Plan of the spouse of the parent with custody of the child;

(d) then, the Plan of the parent not having custody of the child, and

(e) finally, the Plan of the spouse of the parent not having custody of the child.

GM6000 COB13 M

(4) The Plan that covers a person as an active Employee (or as a Dependent thereof) shall be the Primary Plan, and the Plan that covers that person as laid-off or retired Employee (or as a Dependent thereof) shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(5) The Plan that covers a person under a right of continuation which is provided by federal or state law shall be the Secondary Plan, and the Plan that covers that person as an active or retired Employee (or as a Dependent thereof) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(6) If one of the Plans that covers an insured is governed by the laws of the state whose laws govern this Plan; and that Plan determines the order of benefits based upon the gender of a parent; and, as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered an insured for the longer period of time shall be Primary.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

GM6000 COB14V7 M

Recovery of Excess Benefits

If CG pays benefits for charges that should have been paid by the Primary Plan; or if CG pays benefits for charges in excess of those for which it is obligated to provide, CG will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

CG will have sole discretion to seek such recovery from any person to or for whom, or with respect to whom, such services were provided or such payments made, by any insurance company, health care plan, or other organization. If requested, the insured must execute and deliver to CG such instruments and documents as it determines are necessary to secure the right of recovery.

Right to Receive and Release Information

CG, without consent or notice, may obtain information from, and release information to, any other Plan in order to coordinate benefits pursuant to this section. The insured must provide the Plan with any information it requests in order to coordinate benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, the insured will be advised that "other coverage" information (including an Explanation of Benefits [EOB] paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

GM6000 COB15 M

Expenses For Which A Third Party May Be Liable

This Policy does not cover expenses for which another party may be responsible as a result of having caused or contributed to the Injury, Sickness or condition. If you incur a Covered Dental Expense for which, in the opinion of CG, another party may be liable:

(1) CG shall, to the extent permitted by law, be subrogated to all rights, claims, or interests which you may have against such party and shall automatically have a lien upon the proceeds of any recovery by you from such party, to the extent of any benefits paid under the Policy. You or your representative shall execute such documents as may be required to secure CG's subrogation rights.

(2) Alternatively, CG may, at its sole discretion, pay the benefits otherwise payable under the Policy. However, you must first agree in writing to refund to CG the lesser of:

(a) the amount actually paid for such Covered Dental Expenses by CG; or

(b) the amount you actually receive from the third party for such Covered Dental Expenses;

at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration or award, or otherwise.

GM6000 CCP7 CCL7 M

Facility of Payment

To Whom Payable

The Policyholder and CG agree that, except in the case of Emergency Dental Services received from a non-Participating Dentist, all Dental Benefits will be paid directly to the person or institution providing the dental care. Any Dental Benefits for Emergency Dental Services received from a non-Participating Dentist will be paid, at the option of CG, either to you or to the person or institution providing the dental care.

If any person to whom benefits are payable is a minor or, in the opinion of CG, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. However, if no request for payment has been made by his legal guardian, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

Payment as described above will release CG from all liability to the extent of any payment made.

GM6000 POB5V-10 PMT121 M

Miscellaneous

Certain Participating Dental Facilities may provide discounts on services not listed in the Patient Charge Schedule, including a 10% discount on bleaching services. You should contact your Participating Dental Facility to determine if such discounts are offered.

GM6000 POB2

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or otherwise cease to qualify for the insurance.
- the last day of the calendar month following the month for which you have made any required contribution for the insurance.
- the date of a continuing lack of Participating Dental Facilities in your area (as determined by CG).
- the date of any determination of fraud or misuse, on your part, of dental services and/or dental facilities
- the date you relocate to an area where the Dental plan is not offered.
- the date the policy is canceled.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

Your insurance will cease on the date you are no longer Actively at Work, except that:

- while you are sick or injured, and in an approved, leave-without-pay period, your employment will be deemed to continue for up to 12 months from the date your disability began, as long as premium payments continue to be made on your behalf; and
- while you are on an approved leave of absence (except a leave of absence to enter military or naval service), your employment will be deemed to continue, as long as premium payments continue to be made on your behalf, for up to 12 months, unless your Employer cancels your insurance before the end of that time.

Injury or Sickness

If you are no longer Actively at Work due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, the insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels the insurance.

Retirement

If your Active Service ends because you retire, your insurance will be continued until the earlier of:

- the date you disenroll;
- your death;
- the date your annuity is insufficient to cover the required premium;
- the date on which your Employer cancels the insurance.

GM6000 TRM15V3 M

Dependents

Insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases, except when you die.
- the date you cease to be eligible for Dependent Insurance.
- the last day of the calendar month following the month for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.
- the date of a continuing lack of Participating Dental Facilities in your area (as determined by CG).

Insurance for any one of your Dependents will cease on:

- the date he or she no longer qualifies as a Dependent.

- the date of any determination of fraud or misuse, on your Dependent's part, of dental services and/or dental facilities.

Retiree and Surviving Dependents Continuation of Coverage

Employees who are eligible to participate and were enrolled in the dental option at the time of retirement on or after April 1, 1997, may be eligible for continuing their dental coverage through their retirement annuity.

The term *Retired Employee* means an Employee who:

(1) was enrolled under the Flexible Benefits Program dental plan with continuous coverage on or after April 1, 1997; and

(2) is eligible to receive an immediate and sufficient monthly benefit from the Employees' Retirement System, Legislative Retirement System, Teachers Retirement System, Public School Employees' Retirement System, Superior Court Judges Retirement System, or District Attorney's Retirement System; and

(3) elects to participate in the Flexible Benefits Program dental plan as a retiree under one of the above retirement systems.

The term *Surviving Dependent* means a person who:

(1) was covered as a Dependent spouse or child by an active or Retired Employee under the Flexible Benefits Program dental plan; and

(2) is eligible as a beneficiary of the active or Retired Employee for an immediate and sufficient monthly benefit from the Employees' Retirement System, Legislative Retirement System, Teachers Retirement System, Public School Employees' Retirement System, Superior Court Judges Retirement System, or District Attorney's Retirement System; and

(3) elects to participate in the Flexible Benefits Program dental plan as a Surviving Spouse/Dependent under one of the above retirement systems; and

(4) is not otherwise eligible to participate in the Flexible Benefits Program dental plan as an active Employee, or as a Dependent Child covered under another active Employee.

Eligibility

To be eligible to enroll in the dental plan as a Retired Employee or Surviving Dependent, you must meet the definition above of a Retired Employee or Surviving Dependent, and have been continuously covered (with no lapse in coverage) under the Flexible Benefits Program dental plan. In addition, a Flexible Benefits Program "Retiree/Surviving Spouse Enrollment Form for Dental Coverage" must be completed to authorize deductions for dental insurance by the Employee's applicable retirement system.

A Retired Employee or Surviving Dependent will be subject to certain *Terms and Conditions* not applicable to an active Employee, such as **not** having an annual Open Enrollment Period. However, upon the initial enrollment as a Retired Employee or Surviving Spouse/Dependent, the following changes are allowed:

Change of Dental Option. A change of dental option means a transfer to or from: (a) the dental Preferred Provider Organization (PPO); (b) the regular dental option; or (c) the prepaid option.

- At the time of enrollment, a transfer may be made to any option. To enroll in the PPO option, a person must live in the metropolitan Atlanta, Augusta, Macon, Savannah, or Valdosta areas, or have a PPO available in their area. To enroll in the Prepaid option, a person must live in the metropolitan Atlanta area.
- If a person relocates from a PPO or Prepaid service area, a change from the PPO or Prepaid option to the regular dental insurance option is permitted. However, once a change is made, re-enrollment in the PPO or Prepaid option is not permitted.

Change of Dental Coverage Type. A change of dental coverage type means a change between Single and Family coverage. The following changes are allowed:

- A change from Family to Single dental coverage is allowed, upon request.
- retirees are allowed to change from Single to Family dental coverage upon acquisition of a Dependent by marriage, birth, adoption, or for certain other changes in family status, provided the request and documentation is filed not later than 30 days following the event. Surviving Dependents cannot change from Single to Family dental coverage.

A surviving spouse of a deceased Employee enrolled in the dental plan may elect dental coverage as a Surviving Dependent spouse; or, if the spouse is an active Employee, through payroll reduction. The surviving Dependent spouse cannot elect dual coverage under this plan.

Upon death of an active or retired Employee, an eligible surviving Dependent child who was insured under the family dental plan and is the principal beneficiary under one of the retirement systems may continue coverage, until such time as he or she no longer meets the eligibility requirements.

The Dependent child may *not* be insured under the retiree dental provision if he or she is: (a) insured as a Dependent child under another active or retired Employee; or (b) eligible as an active Employee.

A Surviving Dependent will be eligible for dental deductions **only** if he or she is receiving an immediate and sufficient benefit from an eligible retirement system. If the annuity is insufficient, the Surviving Dependent will be eligible for continuing coverage under the "Temporary Coverage Continuation."

GM6000 TRM72V4 M

Dental Benefits Extension

A Dental Service that is completed after a person's benefits cease will be deemed to be completed while he is insured, if:

- for fixed bridgework and full or partial dentures, the final impressions are taken and/or abutment teeth fully prepared while he is insured, and the prosthesis inserted within 3 calendar months after his insurance ceases.
- for a crown, inlay, or onlay, the tooth is prepared while he is insured, and the crown, inlay, or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured, and the treatment is completed within 3 calendar months after his insurance ceases.
- for orthodontic services, the treatment commences while the person is insured, and the expenses are incurred within 60 days after his insurance ceases.

There is no extension for any Dental Service not shown above.

This extension of benefits does not apply if insurance ceases due to nonpayment of premiums.

GM6000 BEX184 M

Dental Conversion Privilege

Any Employee or Dependent whose Dental Insurance ceases for a reason other than failure to pay any required contribution or cancellation of the policy may be eligible for coverage under another group Dental Insurance policy underwritten by CG, provided that: (a) he applies in writing, and pays the first premium to CG within 30 days after his insurance ceases; and (b) he is not considered to be overinsured.

CDH, CG or, as the case may be, the Policyholder, will give the Employee, upon request, further details of the Converted Policy.

Conversion is not available if your insurance ceased due to:

- nonpayment of required premiums;
- selection of alternate dental insurance by your group;
- a permanent breakdown of the Dentist/patient relationship; or
- fraud or misuse of the Dental Plan.

GM6000 PRO64M

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this document, the provision which results in the richer benefit will apply.

FDRL1V2 M

Qualified Medical Child Support Order (QMCSO)

A. Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order.

You must notify your Employer and elect coverage for that child (and yourself, if you are not already enrolled) within 30 days of the QMCSO being issued.

B. Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree, order (including approval of a settlement agreement), or administrative notice which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or health benefit coverage to such child, relates to benefits under the group health plan, and satisfies all of the following:

(1) the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;

(2) the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;

(3) the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;

(4) the order states the period to which it applies; and

(5) if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

C. Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

FDRL2V1 M

Eligibility for Coverage for Adopted Children

Any child under the age of 19 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption. If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

FDRL6 M

Federal Tax Implications for Dependent Coverage

Payments for Dependent health coverage are usually exempt from federal income tax consideration. Generally, if you can claim an individual as a Dependent for the purposes of federal income tax, then the cost for that Dependent's health coverage will not be taxable to

you as income. However, in the rare instance that you cover an individual under your health benefits who does not meet the federal definition of a Dependent, the cost may be taxable to you as income. If you have questions concerning your specific situation, you should seek the counsel of your own tax consultant or attorney.

FDRL7 M

Group Plan Coverage Instead of Medicaid

If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the Social Security income level, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

FDRL10

Requirements of Medical Leave Act of 1993 (FMLA)

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable:

A. Continuation of Health Insurance During Leave

Your dental insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an eligible Employee under the terms of that Act.

The cost of your dental insurance during such leave must be paid, whether entirely by your Employer; in part by you and your Employer; or entirely by you.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled dental insurance will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period to the extent that it had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

FDRL13 M

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's Military Leave of Absence. These requirements apply to medical and dental coverage for you and your Dependents.

A. Continuation of Coverage

This dental policy provides an exclusion for "dental care resulting from any Injury or Sicknes sustained as a result of war, declared or undeclared, or any action or war or any resistance to armed invasion or aggression or international police action." You may choose to discontinue dental coverage while on Military Leave, or continue coverage through personal premium payments. You may pay personal premium payments as long as you are on the Military Leave. Since both the commencement and completion of Military Leave is considered a Qualified Change of Status, you may also select a different dental option at these times.

If you do not continue coverage through personal premium payments, you will be reinstated upon return to employment for the type of dental coverage for which you enrolled prior to activation, unless a different option is selected. No penalties for non-payment will be applied.

The administration of the dental benefit described above is based on your returning to work during the same plan year that you were placed on Military Leave. If you return to work in a different plan year, you will be provided a thirty (30) day Open Enrollment Period for the new plan year. You are guaranteed coverage for benefits in effect prior to the onset of your Military Leave.

If a qualifying change in status occurs while on you are on Military Leave, you should report the change to the personnel/payroll office upon return to active pay status. If you do not report the change at that time, it must be reported within the allowable timeframe. Generally, a request for an increase in coverage must be made within thirty (30) days; a request for a decrease in coverage must be made within thirty (30) days.

For leaves of less than 31 days, coverage will continue as described in the **Termination** section regarding "Leave of Absence."

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents, subject to the terms of the section entitled, "Continuation Rights Under Federal Law (COBRA)," for which your Employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA or COBRA requirements, you may convert to a plan of individual coverage according to the "Conversion Privilege" shown in this certificate.

B. Time Frames for Requesting Reemployment

When a Military Leave ends, you must report your intent to return to work as follows.

- For leaves of less than 31 days or for a fitness exam: By reporting to your Employer by the next regularly-scheduled work day following 8 hours of travel time;
- For leaves of 31days or longer, but less than 181 days: By submitting an application to your Employer within 14 days; and

- For leaves 181 days or longer: By submitting an application to your Employer within 30 days.

Consult with your Employer for further details regarding your rights, including reinstatement of coverage, and your Employer's obligations for reemployment.

FDRL58 M

Continuation Rights Under Federal Law (COBRA)

For You and Your Dependents

You are receiving this notice because you have recently become covered under the Prepaid Dental Plan for the State of Georgia Flexible Benefits Program (the Plan). This notice contains important information about your right under federal mandate to a temporary extension of coverage under the Plan. The right to continuation coverage was created by a federal law called the "Consolidated Omnibus Budget Reconciliation Act of 1985" (and referred to as "COBRA"). COBRA continuation coverage can become available to you and to other members of your family who are insured under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under COBRA, you should contact your Flexible Benefits Program Administrator ("Program Administrator").

The Program Administrator's address is:

Flexible Benefits Program
State Personnel Administration
2 Martin Luther King, Jr. Drive, Suite 1016
West Tower, Atlanta, Georgia 30334

The Program Administrator is responsible for administering COBRA continuation coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of insurance under the Plan when coverage would otherwise end because of a life event known as a "qualifying event". (Specific qualifying events are listed later in this notice.) COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, Employees, their Dependent spouses, and Dependent children of Employees may be qualified beneficiaries.

Who is Entitled to COBRA Continuation?

As an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events occurs:

(1) Your hours of employment are reduced; or

(2) Your employment ends for any reason other than gross misconduct.

Your Dependent spouse will become a qualified beneficiary if you lose your coverage under the Plan because one of the following qualifying events occurs:

(1) Your death;

(2) Your hours of employment are reduced;

(3) Your employment ends for any reason other than gross misconduct;

(4) You become enrolled in Medicare (Part A, Part B, or both); or

(5) You become divorced from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because one of the following qualifying events occurs:

(1) Your death;

(2) Your hours of employment are reduced;

(3) Your employment ends for any reason other than gross misconduct;

(4) You become enrolled in Medicare (Part A, Part B, or both);

(5) You and your spouse divorce; or

(6) The child stops being eligible for coverage under the plan as a "Dependent child, upon attainment of age 19, or 26 if a full-time student".

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Program Administrator has been notified in a **timely fashion** that a qualifying event has occurred. When the qualifying event is the end of employment or a reduction of hours of employment, death of the Employee, or enrollment of the Employee in Medicare (Part A, Part B, or both), the Employer must notify the Program Administrator within sixty (60) days after the later of: (a) the qualifying event; or (b) the loss of coverage.

Important: For the other qualifying events (i.e., divorce; or a Dependent child's loss of eligibility for coverage as a Dependent child), you must notify the Program Administrator. The Plan requires you to notify the Program Administrator in writing within 60 days after the later of: (a) the qualifying event; or (b) the loss of coverage, using the procedures specified below. ***Note:*** *If these procedures are not followed; or if written notice is not provided to the Program Administrator during the 60-day notice period, any Dependent spouse or child who loses coverage will not be offered the option to elect continuation coverage.*

Notice Procedures: Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail your notice to the Program Administrator of the Flexible Benefits Program of the State Personnel Administration at this address:

2 Martin Luther King, Jr. Drive, Suite 1016
West Tower, Atlanta, Georgia 30334

You may contact the Program Administrator to obtain the form (if any) used to provide notice to the Program Administrator of a qualifying event.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state: (a) the name of the Plan (Group Dental Insurance Plan); (b) the name and address of the Employee insured under the Plan; and (c) the name(s) and address (es) of the qualified beneficiary (ies). Your notice must also name the qualifying event and the date it happened. If the qualifying event is a divorce, your notice must include a copy of the divorce decree.

Once the Program Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage in a **timely fashion**, such continuation coverage will begin on the date of the qualifying event. ***Note:*** *If you or your Dependent spouse or children do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.*

Termination of COBRA Continuation

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is:

- your death;
- your enrollment in Medicare (Part A, Part B, or both);
- your divorce or legal separation; or
- a Dependent child losing eligibility as a dependent child;

COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is:

- the end of your employment for any reason other than gross misconduct; or
- a reduction in your hours of employment;

COBRA continuation coverage lasts for up to 18 months. There are several ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension

If you or anyone in your family insured under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must occur before the **60th** day of COBRA continuation coverage, and must last at least until the end of the 18-month period of continuation coverage. The Plan requires you to follow the "Notice Procedures" specified above. Your notice must address the determination of disability by the Social Security Administration, and the date the disability occurred. ***Note:*** *In the disability determination, if these procedures are not followed or if the notice is not provided, in writing, to the Program Administrator within the required 60-day period, there will be no extension of COBRA continuation coverage due to the determination of disability by the Social Security Administration.*

Secondary Qualifying Events

If your family experiences another qualifying event while receiving COBRA continuation coverage, your Dependent spouse and children can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to your Dependent spouse and children if you become divorced or legally separated. The extension is also available to a Dependent child when that child ceases to be eligible under the Plan as a Dependent child. In both of these cases, you must notify the Plan Administrator, in writing, of the second qualifying event within 60 days of the date it occurs. The Plan requires you to follow the "Notice Procedures" specified above. Your notice must also name the second qualifying event and the date it occurred. ***Note:*** *In the second qualifying event, if these procedures are not followed or if the notice is not provided, in writing, to the Program Administrator within the required 60-day period, there will be no extension of COBRA continuation due to the second qualifying event.*

Medicare Extension for Your Dependents

If a qualifying event that is either:

- a termination of your employment for any reason other than gross misconduct; or
- a reduction in your hours of employment;

occurs within 18 months after you become entitled to Medicare, then the maximum coverage period for hyour Dependent spouse and children will end three (3) years from the date you became entitled to Medicare; however, your maximum coverage period will be 18 months.

Newly-Acquired Dependent Children

A child born to, adopted by or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate Recipients Under QMCSOs

A child of yours who is insured under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Program Administrator while you were employed with the Employer is entitled to the same rights under COBRA as any other Dependent child of

yours, regardless of whether that child would otherwise be considered a Dependent.

Keep Your Plan Informed of Address Changes

In order to protect the rights of you and your family, you should keep the Program Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

FDRL20V1 M FDRL23 M
FDRL21 M FDRL24V2 M
FDRL22V1 M FDRL25V1 M

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance, and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (referred to herein as "eligible individuals"). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center, toll-free, at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at:

www.doleta.gov/tradeact/2002act_index.asp

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60-day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under “Termination of COBRA Continuation” provisions above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

FDRL26 M

Notice of an Appeal or a Grievance

The appeal or grievance provisions in this certificate may be superseded by the laws of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

GM6000 NOT90

The Following Will Apply To Residents of Georgia:

When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you," "your," or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free telephone number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call us (or write to us) at the following:

> Customer Services toll-free telephone number (or address that appears on your benefit identification card, explanation of benefits [EOB], or claim form)

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible; but in any case, within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

CG has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal, in writing, within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved, and include any information supporting your appeal. If you are unable (or choose not) to write, you may ask to register your appeal by telephone. Call us (or write to us) at the toll-free telephone number (or address on your Benefit Identification card, explanation of benefits, or claim form).

GM6000 APL320V1 M

Level-One Appeal

Your appeal will be reviewed, and the decision made, by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond, in writing, with a decision within 30 calendar days after we receive an appeal for a post-service coverage determination. If more time or information is needed to make the determination, we will notify you, in writing, to request an extension of up to 15 calendar days, and to specify any additional information needed to complete the review.

GM6000 APL321V1 M

Level-Two Appeal

If you are dissatisfied with our level-one appeal decision, you may request a second review. To start a level-two appeal, follow the same process required for a level-one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decisions may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will include at least one Dentist reviewer in the same (or a similar) specialty as the care under consideration, as determined by CG's Dentist reviewer, and will include one Dentist other than CG's Dentist reviewer. You may present your situation to the Committee in person or by conference call.

For level-two appeals, we will acknowledge, in writing, that we have received your request, and schedule a Committee review. For post-service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you, in writing, to request an extension of up to 15 calendar days, and to specify any additional information needed by the Committee to complete the review. You will be notified, in writing, of the Committee's decision within five (5) working days after the Committee meeting; and within the Committee review time frames above, if the Committee does not approve the requested coverage.

GM6000 APL323V2 M

Independent Review Procedure

If you are not fully satisfied with the decision of CG's level-two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The request for independent review may be submitted only by an insured; the parent or guardian of an insured who is a minor; or a legal guardian or representative of an insured who is incapacitated. The Independent Review Organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. CG will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply:

(a) the cost of the service in question must be $500 or more;

(b) you must have exhausted the above Appeals procedures and remain dissatisfied;

(c) the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CG; or

(d) the proposed treatment is excluded as experimental, and: (1) you have a terminal condition with a substantial probability of causing death within two years or impairing your ability to regain or maintain maximum function; (2) the standard treatments have been exhausted, and the treating Dentist certifies that there is no standard treatment available under this certificate more beneficial than the proposed treatment; (3) the treating Dentist certifies, in writing, that the treatment is likely to be more beneficial than any available standard treatment; and (4) the treating Dentist certifies, in writing, that scientifically valid studies demonstrate that the proposed treatment is likely to be more beneficial to you than available standard treatment.

Administrative, eligibility, or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must complete the written request form and forward it to the Georgia state planning agency. The planning agency will select an Independent Review Organization to review the issue, and the Independent Review Organization will make a determination that is binding upon CG.

The Independent Review Organization will render an opinion within 15 working days following receipt of all necessary information. When requested, and when a delay would be detrimental to your condition (as determined by the treating health care provider), the review shall be completed within 72 hours of receipt of all necessary information.

The Independent Review Program is a voluntary program arranged by CG.

GM6000 APL326 M

Appeal to the State of Georgia

You have the right to contact the Department of Insurance or the Department of Human Resources for assistance at any time. The Department of Insurance or the Department of Human Resources may be contacted at the following respective addresses and telephone numbers:

Georgia Department of Insurance
2 Martin Luther King, Jr. Drive
Floyd Memorial Bldg, 704 West Tower
Atlanta, GA 30334
Tel: 404-656-2056

Georgia Department of Human Resources
Two Peachtree Street, NW, Suite 33.250
Atlanta, GA 30303-3167
Tel: 404-657-5550

GM6000 APL329 M

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided, in writing or electronically, and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other Relevant Information, as defined; (4) a statement describing any voluntary appeal procedures offered by the plan; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in

making the adverse determination regarding your appeal; and (6) an explanation of the scientific or clinical judgment for a determination that is based on Medical Necessity, experimental treatment, or other similar exclusion or limit.

You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to determine what options may be available to you is to contact your local U.S. Department of Labor office, or your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

"Relevant Information" refers to any document, record, or other information which: (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit, or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

In most instances, you may not initiate a legal action against CG in federal court until you have completed the Level-One and Level-Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level-Two process prior to bringing legal action.

GM6000 APL327 M

Definitions

Active Service

You will be considered in Active Service if:

- you are able to do the normal tasks of your job on a full-time basis for a full work day on the date your insurance is scheduled to become effective; and
- you are able to do such tasks at one of your Employer's normal places of business, or at a location to which you must travel to do your job; and
- you are not absent from work due to Sickness, disability, or temporary lay-off.

DFS1

CIGNA Dental Health (herein referred to as CDH)

CDH is a wholly-owned subsidiary of CIGNA Corporation that, on behalf of CG, contracts with Participating General Dentists for the provision of dental care. CDH also provides management and information services to Policyholders and Participating Dental Facilities.

DFS592

Dentist

The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Dental Services described in the policy.

DFS24

Dependent

Dependents are:

- your lawful spouse; and
- any unmarried child of yours who is
  - less than 24 years old, and primarily supported by you;
  - 24 years old or older, but less than 26 years old, enrolled in school as a full-time student, and primarily supported by you;
  - 19 years old or older, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 30 days after the date the child ceases to qualify above. During the next two years, CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

The term "child" includes a legally adopted child from the first day of placement in your home, regardless of whether the adoption has become final. It also includes a foster child or stepchild who lives with you.

Benefits for a Dependent child or student will continue until the last day of the calendar month in which the limiting age is reached.

DFS2055

Employee

The term Employee means a person who:

- is a full-time employee of the State of Georgia, or a State Agency. "Full-time" means someone who works at least 30 hours a week, on a continuous basis, and whose employment is expected to last at least nine (9) months. [The following are certain categories of employees specifically excluded: student, seasonal, part-time, short-term and sheltered workshop]; or
- is a public school teacher who is employed in a professionally certificated capacity working 17.5 hours or more per week.
- is an employee of a local school system who holds a non-certificated position and who is eligible to participate in the Teachers Retirement System or its equivalent and working at least 20 hours a week (or 60% of the time necessary to carry out the duties of the position if that's more than 20 hours); or
- is an employee who is eligible to participate in the Public School Employee Retirement System as defined by 20 of Section 47-4-2 of the Official Code of Georgia, Annotated and who works at least 15 hours a week (or 60% of the time necessary to carry out the duties of the position); or

- is an employee of a county or regional library and working at least 17.5 hours or more; or
- is deemed eligible by Federal or Georgia state law.

DFS211

Employer

The terms Employer and Participating Employer refer to any Employer who has signed a Request for Participation in the Tennessee CIGNA Dental Care/Options Trust and whose request has been approved by the Insurance Company. These terms also include Affiliated Employers. "Affiliated Employers" are those Employers specified as affiliated employers in the Participating Employer's Request for Participation, in accordance with its terms.

DFS1637

Injury

The term Injury means an accidental bodily injury.

DFS147

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 (as amended).

DFS192

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 (as amended).

DFS149

Participating Dental Facility

The term Participating Dental Facility means an approved dental care facility for the provision of ordinary and customary dental care, with such care to be provided at predetermined fees as negotiated by CG and CDH.

The Participating Dental Facilities and Participating General Dentists may change from time to time. A list of the current Participating Dental Facilities will be provided to the Policyholder periodically by CDH for the purpose of Employee selection of a Participating Dental Facility.

DFS593

Participating General Dentist

The term Participating General Dentist means a person practicing dentistry within the scope of his license at a Participating Dental Facility, under the terms of his provider contract with CDH.

DFS594

Participation Date

The term Participation Date means the later of:

- The Effective Date of the policy; or
- The date on which your Employer becomes a participant in the plan of insurance authorized by the agreement of Trust.

DFS245

Patient Charge Schedule

The Patient Charge Schedule, provided by CDH, is a separate list of covered services and amounts payable by you.

DFS1102

Sickness

The term Sickness means a physical or mental illness. It also includes pregnancy.

DFS184

Specialist

The term Specialist means any person or organization licensed as necessary: (a) who delivers or furnishes specialized dental care services; and (b) who provides such services upon approved referral to persons insured for these benefits.

DFS598

Usual Fee

The customary fee that an individual Dentist most frequently charges for a given dental service.

DFS1834